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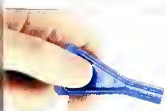
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8 March 2008



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CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product characteristics for full Prescribing Information). Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment:* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients*

with end stage renal disease: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation:* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product



Date of preparation: November 2007 CHA354b

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[†] Based on the Minnesota Nicotine Withdrawal Scale (MNWS), Brief Questionnaire of Smoking Urges (BSU-brief) and modified Cigarette Evaluation Questionnaire (mCEQ).

ffects their ability to perform these activities. **Side-Effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side-effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side-effects were increased appetite, tremor, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for less commonly reported side-effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has not been shown to be dialysed in patients with end stage renal disease, however, there is no experience with dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 10/2007

Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. 2. Jorenby DE *et al.* JAMA 2006; 296:56-63. 3. Tonstad S *et al.* JAMA 2006; 296:64-71. 4. Coe JW *et al.* J. Med. Chem 2005; 48:3474-3477. 5. Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. 6. CHAMPIX Summary of Product Characteristics.





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Presentation: Etopan XL Tablets containing 600mg of etodolac in a film-coated prolonged release formulation. **Indications:** Acute or long-term use in rheumatoid arthritis and osteoarthritis. **Dosage and Administration:** Adults: One 600mg tablet daily. Elderly: No change in dosage is generally required unless renal or hepatic function is impaired. Children: Use in children is not recommended. **Contraindications:** Patients with: existing, or a history of, peptic ulceration/haemorrhage; hypersensitivity to etodolac or any of the excipients; a history of asthma, rhinitis or urticaria during therapy with aspirin or other NSAIDs; severe heart failure. **Special Warnings and Precautions:** Caution is required in patients with: a history of hypertension and/or heart failure, existing or a history of, bronchial asthma, compromised platelet function; a history of GI disease (ulcers, ulcerative colitis, Crohn's disease) as their condition may be exacerbated; rare hereditary problems of galactose intolerance, the Lap lactase deficiency or glucose-galactose malabsorption. Patients with renal, cardiac or hepatic impairment should be monitored in case of deterioration following the use of any NSAID. Patients on long-term treatment should be regularly reviewed for changes in renal or hepatic function or haematological parameters. It any sign of GI bleeding or serious skin reactions, including skin rash, mucosal lesions or

other signs of hypersensitivity occur, treatment should be stopped immediately. The elderly are at an increased risk of side effects, particularly GI effects that can be fatal. Undesirable effects may be minimised by using the minimum effective dose for the shortest possible duration. Etodolac SR Tablets should not be used during pregnancy and its use in nursing mothers should be avoided. **Interactions:** Corticosteroids (increased risk of GI effects) NSAIDs may enhance the effects of anti-coagulants such as warfarin. Concomitant use of ciclosporin, methotrexate, digoxin or lithium with NSAIDs may cause an increase in serum levels of these compounds and associated toxicities. Care should also be taken in patients treated with anti-hypertensives, mifepristone (NSAIDs should not be used for 8-12 days after mifepristone administration), other analgesics including all other NSAIDs, gonulone antibiotics (increased risk of developing convulsions). **Undesirable Effects:** The most commonly observed adverse events are gastrointestinal in nature: Peptic ulcers, perforation or GI bleeding, sometimes fatal. Nausea, vomiting, diarrhoea, flatulence, constipation, dyspepsia, abdominal pain, melaena, haematemesis, ulcerative stomatitis, exacerbation of colitis and Crohn's disease. Less frequently, gastritis. Long-term treatment may be associated with arterial thrombotic events. Other side effects include:

Anaphylactoid reactions, serious skin disorders including Stevens-Johnson syndrome and toxic epidermal necrolysis, hepatic function abnormalities and jaundice; oedema, hypertension and cardiac failure; renal problems including renal failure; blood dyscrasias. Prescribers should consult the Summary of Product Characteristics in relation to other side effects. **Legal Category:** POM. **Product Licence Numbers:** 15842/0039. **Date of Preparation of API:** July 2007. **Marketing Authorisation Holder:** Taro Pharmaceuticals (UK) Ltd, Lakeside House, 1 Furzeground Way, Stockley Park East, Uxbridge, UB11 1BD. **Sole Distributors:** Winthrop Pharmaceuticals UK Ltd, One Onslow Street, Guildford, Surrey, GU1 4YS. **For medical information phone:** +44 8707 369544. **For all other information available freephone:** Winthrop 0800 854431.

Information about adverse event reporting can be found on www.yellowcard.gov.uk. Adverse events should also be reported to the Taro UK Office Tel +44 8707 369544/ email: regulatory@taropharma.co.uk

For further information please freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey, GU1 4YS. Fax number 01483 554809. Date of preparation: August 2007 STW 336

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Chemist+Druggist

news education tools

Comment from the Editor

If a pharmacist launched a new service that led to hundreds of dispensing errors, they'd be struck off before you could say Jack Robinson. Yet, new technology at the Prescription Pricing Division is leading to numerous errors in prescription payments and the sector is expected to take the strain in sorting out the problem.

PSNC expects pharmacists to trawl through payments dating back to March last year to spot "erroneous switching" of scripts from exempt to paid status. Some "teething problems" with the PPD's screening system are to blame, PSNC states. But don't worry, the contract negotiator adds, PPD and PSNC have been scrutinising the system closely. Not closely enough, it would appear. The system should never have gone live if it could not be trusted to process prescriptions accurately. Pharmacists have enough to deal with without having to worry whether they are being correctly paid for their bread and butter business.

And if the glitches were spotted on day one, pharmacists should have been told. It should not have taken a year to publicise the problem. Without the courage of several contractors in speaking out in C+D, it might not have come to light for even longer.



PSNC's response is to ask for favours in faith that would test the Dalai Lama

The saga has left many sceptical and frustrated. Recent PPD demands for prescriptions to be sorted into sub-categories that would baffle a taxonomist have added to the irritation. Yet PSNC's response is to ask for levels of faith that would test the Dalai Lama. We'll negotiate compensation with the government, it reassures. But what pharmacists want is a more comprehensive breakdown of reimbursements and a cast iron guarantee that payments are correct.

Faced with such frustrations, it's no wonder stress levels have hit an all-time high, according to a survey by buying group Avicenna (p10). And it's not just independents who are suffering. An exclusive survey of nearly 1,000 pharmacists and their staff also shows anxiety on the up at the multiples. See next week's C+D for the full findings.

Max Gosney, News Editor

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PSNC approach too 'soft' on costly prescription switch errors

» The contract negotiator should insist on automatic safeguards, say contractors

Jennifer Richardson

Contractors have been left out of pocket because the NHS has wrongly switched prescriptions from exempt to paid status, PSNC has said.

Two contractors missing up to £2,000 as a result of prescription switches said the contract negotiator's reaction to the problem did not go far enough.

Investigations into the Prescription Pricing Division's (PPD's) automated prescription scanning system showed most switches were correct identification of wrongly sorted scripts, PSNC chief executive Sue Sharpe said.

But she added: "In other cases, there has been erroneous switching." Pharmacy owners who believed they had fallen victim to such errors could request a review by the PPD.

But Nisheet Patel, of Cokeham Pharmacy in Sompting, West Sussex, said this was a "soft approach". Mr Patel has claimed he had more than 200 prescriptions in one month switched from exempt to paid, a loss of more than £1,300 at the £6.85 prescription charge (C+D, February 9, p6).



PSNC should "insist" on an automatic double-check of any payments with high numbers of switches, he said. "It's not acceptable to say contractors can report it when it's a case of hundreds of items."

And MP Bharj, of Beaver Pharmacy in Hounslow, agreed: "If

there's a glaring change it should be picked up automatically." Mr Bharj said he had 300 scripts, a third of his essential small pharmacy's turnover, switched from exempt to paid in a single month. This would equate to a loss of more than £2,000.

Mr Bharj said he would request

reviews of even small numbers of switches from now on. "I just don't feel confident enough in [the] system."

Have you been hit by incorrect switching?
jrichardson@cmpmedica.com

MPs push for preventative role

MPs have pledged to make pharmacy roles in preventative healthcare into national enhanced services.

At a meeting of the all-party pharmacy group (APPG) on Tuesday, MPs, commissioners and pharmacists heard about a successful anti-coagulant service in Eastern & Coastal Kent PCT, led by pharmacist Michael Eakins of Eakins Pharmacy, Hythe.

Moving the service out of the acute trust into the community through pharmacy had freed up hospital beds and saved the PCT around £380,000 a year, the audience was told.

PCT head of strategic

commissioning Neil Fisher said he did not know why all PCTs were not doing the same thing and he was producing a document so others could learn from Eastern & Coastal Kent's experience.

The success of the service was a result of collaboration between Mr Eakins and local GPs, attendees heard, and poor local relations could be a barrier to the development of the service in other areas.

But roll-out was nonetheless the aim of the APPG. Chairman Howard Stoute MP said: "It's our policy to make this part of enhanced services across the country." JR

MP visits set for double figures

Ten MPs have now said yes to visiting their local pharmacy as part of the C+D Building Bridges campaign.

Tory MPs Stephen Hammond and Simon Burns will carry out the third and fourth visits this week.

Six MP colleagues have agreed to follow suit by the end of the month.

Nearly 40 pharmacists have now signed up to the campaign that aims to get as many MPs, MSPs, MLAs and AMs to visit a pharmacy as possible.

What's happening...

NORTHERN IRELAND
Ian Gabbie of Gabbies Pharmacy, Killyleagh to take up MLA Kieran McCarthy on his offer to visit a local pharmacy

WALES
Five Rowlands pharmacists sign up to Building Bridges

ESSEX
Simon Burns to visit Waldmans Pharmacy near Chelmsford

CRAWLEY
Laura Moffatt to visit Lloyds-pharmacy in Langley Green

Put on spot by patient prescription dilemma

Patients unable to afford multiple items asking pharmacists to choose for them

Jennifer Richardson

Patients are asking their pharmacists to choose between their prescribed medicines, because they cannot afford to pay for more than one item, a multiple has said.

Co-operative Pharmacy managing director John Nuttall said prescription charges were a barrier to patient access to medication.

"It is not uncommon for pharmacists in Co-operative Pharmacy branches to be asked to choose which medication a customer should pay for on their prescription, because they can only afford one item," he said.

His comments followed a survey by the charity Citizens Advice, which revealed that 800,000 people in England failed to collect a prescription last year because of the cost.

PDA director John Murphy said he was unsurprised by Mr Nuttall's claim. "That puts the pharmacist in a very difficult position," he added.

An RPSGB spokesperson said the Society had no official guidance for dealing with such a request. Head of practice Heidi Wright added: "The Society would always recommend that a patient receives and takes the full course of their prescriptions."

Mr Nuttall and Mr Murphy agreed patients should be encouraged to take all prescribed medication. If this failed, pharmacists could contact the patient's GP to discuss the problem, they suggested.

If this did not solve the problem, a pharmacist would need to make a professional decision on an individual case basis, Mr Murphy said, as to whether to help the patient choose between their medicines.

"One would hope there wouldn't be any comeback if they did, in their professional judgment, make a decision," he added.

Keep up with EPS releases

Pharmacists burying their heads in the sand about EPS have been warned that once release two roll-out begins, there may be little chance to catch up.

Speaking exclusively to C+D, Tim Donohoe, group programme director of Connecting for Health, said he hoped "the technical infrastructure that was put in place for release one will enable it to be done much more quickly".

Many pharmacists are eager for

release two to start, with PSNC reporting that its information team was frequently asked about the subject in February. But for those businesses left behind, there could be serious implications once patients start nominating particular pharmacies to receive their prescriptions.

This week, guidance has been launched for pharmacists on both EPS and on release two, as well as an EPS logo, which will be printed

on pharmacy signs to help patients see which pharmacies are release two enabled.

Andy Charlesworth, commercial IT manager at Numark, warned the logo could bring a competitive edge to release two. He said: "It's going to become quite obvious [to patients] those people who have become release two compliant."

For more information go to www.connectingforhealth.nhs.uk and www.psnc.org.uk **ZS**

In next week's issue...

 **Survey**

News in brief

PPRS end date set

The DH has set a date for the termination of the current pricing deal for branded prescription medicines. Pharmaceutical companies in the UK have been told the PPRS will cease on September 1, more than two years ahead of schedule.

Nucare changes

Nucare has moved offices and is seeking a pharmacy development manager. John D'Arcy, Rowlands commercial director, has also confirmed the 35 Nucare-branded pharmacies are now trading under the Rowlands brand. Nucare CEO Mahesh Shah said the group still operated independently.

Lib Dem lobbying

Scottish Liberal Democrat health spokesperson Ross Finnie highlighted pharmacy's role in managing long-term conditions at the party's conference last weekend. RPSGB and Community Pharmacy Scotland joined forces to attend, and lobbied MPs and MSPs on pharmacy access to electronic patient records.

Goldshield settles

Goldshield Pharmaceuticals and Forley Generics have reached a £750,000 settlement with the Scottish government over alleged anti-competitive cartel conduct in the supply of drugs to the NHS. Goldshield has also agreed a £250,000 settlement with the NI government. All payments are made without admission of liability.

Join C+D's team

Are you interested in a career in journalism? C+D has a position for a full-time reporter to join its busy news desk. The job covers news and feature writing for print and online, and training is provided. For more information, contact Gary Paragpuri, C+D's Editor, on 01732 377688 or email gparagpuri@cmpmedica.com

IT issues may slow workflow

There has been little reassurance this week for pharmacists concerned about workflow issues under EPS. Pharmacists with a single screen are worried about how checking and dispensing will work alongside each other without paper prescriptions.

Tim Donohoe, of Connecting for Health, said: "A pharmacy which only has a single screen may have issues and it may mean that over time people do need to



generally invest a bit more in IT." He added that early implementers would test these issues to find solutions.

PSNC's release two guidance says the RPSGB is currently considering issues

around accuracy checking.

But Numark's Andy Charlesworth said the sooner advice came out on the subject the better, so pharmacists would have time to prepare.

Sign up to the Building Bridges campaign at:
www.chemistanddruggist.co.uk/buildingbridges

and where



SCOTLAND

Can we get the Prime Minister to visit? If you are a pharmacist in Gordon Brown's constituency of Kirkcaldy and Cowdenbeath then we want to hear from you

CAMBRIDGESHIRE

Shadow health secretary Andrew Lansley agrees to a visit. Are you a pharmacist in the area who wants to take part?

LONDON

Glenda Jackson to visit Macey Chemists in Gospel Oak.
Stephen Hammond to visit Mount Elgon Pharmacy this Thursday

Dispensary TALK

Would you want a dental clinic in your pharmacy?



"Yes – very much so. I don't know if it's the same in the rest of the country as it is up here as it's horrendous to get NHS dentists up here. There's certainly a demand for it." **Stuart Notman, Stuart Notman Pharmacy, Aberdeen**



"Yes – I've already got one upstairs – it complements the business very well. It is very handy for the public health promotion work we are doing on oral health."

Aina Osunkunle, K & A Pharmacy, Gateshead

WEB VERDICT:

Yes: ☐ 45%
No: ☐ 55%

Armchair view: This was certainly an issue that you got your teeth into, with a pretty even split between those who would welcome a bit of 'Darzisation' – and those who wouldn't.

This week: Have your stress levels gone up in the past year? Vote online at www.chemistanddruggist.co.uk

PSNC 'must review' category M

Independent Pharmacy Federation urges realistic level of prices

Zoe Smeaton

Pharmacy industry leaders have called for an urgent review of category M prices to help independent contractors being "crippled" by the clawback.

The Independent Pharmacy Federation said category M prices must be revised to a realistic level, and that PSNC and the DH should review the costs of operating under the contract. They also called for emergency funding to be given to affected contractors.

John D'Arcy, managing director of Numark, echoed the IPF's fears and urged PSNC to review the situation with the DH.

Fin McCaul, chairman of the IPF, told C+D some pharmacists were down by as much as £2.20 on their average item since October last year. Although other factors such as direct to pharmacy distribution

models could have played a role in this too, he added.

Bharat Pandya, of Healthcare Concepts, which has two pharmacies, told C+D that, since the clawback began, his statements had dropped significantly, causing the business to use its overdraft facility for the first time. He said despite embracing the new contract, with services such as EHC and methadone supervision, they

were now having to cut costs.

A DH spokesperson said they believed the cuts were consistent with the terms of the pharmacy contract. PSNC was unavailable for comment.

• Read your cat M letters on p15.



How have the category M cuts hit you?
zsmeaton@cmpmedica.com

Rowlands champions cancer-fighting role

Pharmacists in the north of England could play a greater role in cancer detection, thanks to a community-led initiative.

Community representatives from some of the most deprived wards in England heard from Rowlands' NHS liaison manager Liz Stafford how community pharmacists could raise awareness of the symptoms of lung, breast and bowel cancer.

At a meeting of the Healthy Communities Collaborative (HCC), led by not-for-profit company the Improvement Foundation, the community representatives also suggested some ideas of their own.

These included pharmacists carrying out MURs or healthy lifestyle checks at HCC awareness days, or using pharmacies to host such events. Pharmacies should also advertise the presence of consultation rooms, representatives said, as many patients were not aware of them.

Rowlands called on pharmacists in participating PCTs to implement



Breast cancer: pharmacists could help to raise awareness of the symptoms

the suggestions to ensure pharmacy was recognised as part of the cancer strategy.

The participating PCTs are Gateshead, Liverpool, Manchester, Newcastle, North Tyneside, South Tyneside, Salford, Sunderland, and Halton & St Helens. **JR**

Can pharmacy help fight cancer?
jrichardson@cmpmedica.com

Get set for push on herbals

Pharmacists are likely to face consumer questions about herbal medicines and targeted advertising campaigns from manufacturers in coming years.

By 2011, all herbal medicines will need to be registered under the MHRA's Traditional Herbal Medicines Registration Scheme, or have a marketing authorisation. The scheme could lead to more consumer interest in the medicines.

Bioforce (UK), which makes the A Vogel brand of herbal medicines, already has some products licensed under the new scheme. Dr Jen Tan, medical director of Bioforce (UK), told C+D: "Pharmacists are a very important channel for us and our activities in speaking to pharmacists will be increasing dramatically."

The company will help to educate pharmacists on herbal medicines, and programmes could contribute to continuing professional development. **ZS**

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Freederm Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Indications:** For the topical treatment of mild to moderate inflammatory acne vulgaris. **Directions:** For adults, children and the elderly. Apply to the affected area twice daily after the skin has been thoroughly washed with warm water and soap. Enough gel should be used to cover the affected area. For cutaneous use. **Contraindications:** Not to be used in cases of sensitivity to any of the ingredients. **Precautions:** For external use only and to be kept away from the eyes and mucous membranes, including those of the nose and mouth. If excessive dryness, irritation or peeling occurs reduce the dosage to one application per day or every other day. Although there are no specific restrictions to using Freederm during pregnancy or breast feeding, the potential risks are unknown. As with all medicines, care should therefore be exercised, particularly during the first trimester of pregnancy. Side-effects: The most frequently encountered adverse effect reported is dryness of the skin. Other less frequent adverse effects include pruritus, erythema, burning sensation and irritation. **Legal category:** [P] **Packs:** 25g, RSP £8.95, (£7.62 exc. VAT) PL 0173/0166 **Revision Date:** [] January 2008

News in brief

Decongestant reminder

Pharmacists have been reminded that products containing more than 720mg pseudoephedrine or 180mg ephedrine will be prescription-only from April. The MHRA's latest drug safety update said the drugs would still be reclassified in 2009 unless risks from misuse are contained.

Training worries

Concerns about how pharmacy will fare if student funding is reduced for those not taking it as a first degree have been raised in Parliament. The government said the rules would not decrease student numbers and the situation will be reviewed annually.

Welsh services boost

Community Safety Partnerships in Wales, which tackle substance misuse, will receive an extra £9 million over the next three years. The partnerships could fund community pharmacy services, and Community Pharmacy Wales and the RPSGB Welsh Pharmacy Board are working to ensure pharmacy's involvement.

Blood test takes off

A service providing phlebotomy across 25 primary care sites, including 18 pharmacies in Coventry, has provided one in five blood tests in its first three weeks of operation. In a survey, 97 per cent of service users said having a blood test in a pharmacy was more convenient, LPC chief Gam Amar said.

Boots strike

Staff at Boots Logistics in Nottingham have voted to go on strike over a disagreement about terms and conditions. The 726 members of the Union of Shop, Distributive and Allied Workers at the site, which has around 1,000 employees, voted nearly two to one in favour of action.

Call for clean slate

Future professional leadership must not fall into the hands of a re-badged Royal Pharmaceutical Society, the UK Clinical Pharmacy Association (UKCPA) has warned. UKCPA chair Dr Catherine Duggan said: "We have a real opportunity to get the real leadership we want." Read the full story at www.chemistanddruggist.co.uk

Stress levels soaring

Category M highlighted as most significant worry for independent contractors

Jennifer Richardson

Stress among independent

contractors has risen five-fold over the past year, a buying group's survey has shown.

Seventy-five per cent of Avicenna's members felt stressed, making it the third-biggest issue facing them, according to the company's annual survey. In 2007, the figure was just 13 per cent.

Avicenna chief executive Salim Jetha attributed the rise to the survey's most-cited worry – category M. "It's really hitting pharmacists very hard," he said.

Avicenna member Reverend David Croucher, of Niton Pharmacy, Isle of Wight, agreed. Though he did not feel stressed himself, he said: "The stress levels are because you don't know from one month to the next what your NHS cheque is going to be."

This view was supported by the fact that 81 per cent of the survey's 85 respondents felt pessimistic

Avicenna members

52 per cent said the new contract had improved the quality of service they provided



78 per cent felt pessimistic about the future of independent pharmacy



59 per cent had no face-to-face contact with other healthcare practitioners



92 per cent did not discuss PBC with their local GP

about the future profitability of their businesses.

The buying group was exploring ways of relieving members' second-biggest concern – paperwork – Mr Jetha said. Possibilities included training to make fuller use of PMR systems.

Avicenna's survey also indicated that just 8 per cent of members were involved in discussions with their local GP practice over practice-based commissioning. This was "entirely in line" with the IPF's experience, said executive director David Wood.

Is stress a big concern? Find out in next week's C+D as we reveal the results of our salary survey



His Royal Highness The Duke of Kent (second from left) has paid a visit to May and Thomson Pharmacy near Woking, Surrey. Pharmacist Shashi Chandarana (centre) welcomed the Duke and explained the range of health services offered by his local pharmacy, including the stop smoking service and patient support group. Mr Chandarana said: "I simply told him about the day to day life in a busy community pharmacy – the role of which has changed greatly since starting here in 1983." He said that the Duke was "very interested" and asked lots of questions

NW HAG scheme to roll out nationwide?

The days when pharmacists have to be accredited separately by each PCT to provide the same enhanced service could be coming to an end if plans to roll out the North West Harmonisation of Accreditation Group (NW HAG) scheme nationally are adopted.

At a meeting in Manchester last week, delegates representing most of the NHS regions in England and Wales agreed the scheme should go national.

The proposal is that the NW

HAG should take on a national role so its expertise is not lost. Membership will be offered to other NHS regions. However, if regions wish to set up their own groups, the NW HAG will support them and identify joint working arrangements.

The NW HAG was set up to harmonise specific enhanced service accreditation and competency requirements for community pharmacists in 24 PCTs in the north west. Its aims are to

reduce the workload for both PCTs and community pharmacists in introducing and maintaining enhanced services.

The HAG does not try to define service specifications; rather it sets out competency and training frameworks covering services such as EHC supply, smoking cessation, needle and syringe exchange, minor ailments and chlamydia. PG

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The responsible pharmacist... does it apply to hospitals too?

Colin Rodden examines the Department of Health's revamp of how pharmacy is run and finds that hospitals could choose to deregister their pharmacies as a result

Actually no. A surprising number of hospital pharmacies are either registered premises or operate registered pharmacies. Much of this came about when Crown Immunity was removed from the NHS in 1991. Situations then arose that were never envisaged in 1968 when the Medicines Act was passed and there was a lack of clarity, for example, on how Section 55 exemptions – the “business of a hospital” – would be applied.

The registered premises vary from small outpatient areas to large departments. The former may be selling analgesics to help patients avoid paying a prescription charge or to reduce the burden on an A&E department. The latter might include the production of chemotherapy or total parenteral nutrition for individual patients.

The difficulty arises when these products are made for patients outwith that particular hospital, or when a large department supplies a neighbouring trust that doesn't have a pharmacy department. This can be done by a registered pharmacy as wholesaling, or against an individual patient prescription.

It is also quite common for one hospital to provide out-of-hours support to another. Often this is by supplying an out of stock item in order to minimise the delay in the patient receiving the medicine. Some hospitals choose to undertake such activity from registered premises so as to remain within the spirit, and the apparent letter, of the law.

Where the hospital pharmacy is registered, there will always be a pharmacist present. However, this may not be the senior pharmacist envisaged by the responsible pharmacist proposals. Often it is a more junior member of staff who is



“The problem for hospital pharmacies is deciding who should be the responsible pharmacist”

able to contact senior colleagues for managerial and clinical advice if necessary. The more junior pharmacist would certainly not be responsible for SOP production and update.

The problem for hospital pharmacies, then, would be deciding who should be the responsible pharmacist. In a large department it could not be the chief pharmacist. They will have other responsibilities and are unlikely to be within the department for the required amount of time. Neither will they write or update the SOPs. That duty is normally delegated to section heads.

Would the section heads be the responsible pharmacists? Unlikely. Each will have full responsibility for their section, but will have little for

any other section, so they do not meet the criteria either. Unless, of course, each section within the pharmacy department was registered. It is doubtful, however, if any trust would pay multiple premises fees for their hospital pharmacy department unless absolutely unavoidable.

Is there anyone else who might be designated responsible pharmacist? Not really, as no one below the section head would be expected to approve amendments to SOPs.

Having failed to sort out the problem for normal daytime running of the department, can we come to a conclusion for the out-of-hours situation? Again, we cannot. Most systems use more junior staff to cover out-of-hours work. This may be as part of a

residency service, where pharmacists are on site during the hours the pharmacy is normally closed. It may be as part of a system whereby pharmacists are called at home by the hospital if a problem arises. In both scenarios, there are usually insufficient senior staff involved to meet the requirements of the proposals.

If hospitals cannot meet the requirements for the responsible pharmacist, is there a solution to the problem?

The easiest solution is to deregister the pharmacy, although I doubt that this is what the Department of Health had in mind when it produced the proposals. To do so would potentially cause problems for hospitals supplying other hospitals. They would have to rely on the Section 55 exemptions, which were not considered robust enough by various regulators in the early 1990s and are unlikely to be so today. Alternatively, they could apply for a wholesale dealers licence, but the expense and the bureaucracy involved are likely to be the stumbling blocks to that solution.

It is also likely that the ability to supply medicines out of hours will be compromised, unless a pharmacist exercises their professional judgement, puts their faith in Section 55 and supplies a medicine essential for a patient, even though they might be in breach of the law. That would be an interesting one for the Statutory Committee!

It is difficult to see how these proposals, when applied in hospitals, do anything whatsoever to improve patient care. On the contrary, there are situations where they actually impede patient care. **Colin Rodden is national secretary for Scotland, Guild of Healthcare Pharmacists**

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We're having an identity crisis

The accessibility of the community pharmacy network is one of our greatest strengths, we are led to believe. There is no other service, apart from a public house perhaps, that you can rely on finding in high streets of all types up and down the country.

You are more likely to find a village pharmacy these days than a bank, post office, GP surgery, police station or chip shop. This is a priceless asset that the NHS, the Department for Work and Pensions, Parcelforce, Interflora, Amazon and countless other organisations should be fighting over as both a premises for service delivery and a distribution point. Who needs the internet when you've got the community pharmacy network? So why has no one ever come up with any widespread uses other than the distribution of medicines and advice?

The Conservatives have suggested that we run clinics for dental hygienists (C+D March 1, p8). I don't see why not, but it's no more than the latest in an ever increasing list of suggestions that are unlikely to be widely adopted. The multiples' latest wheeze is in-store GPs (C+D, March 1, p6), but this will only ever suit a small minority of large premises.

Other current uses for the country's most under-used network include needle exchange centres and methadone collection points; sites for alternative practitioners, chiropodists and the like; screening

centres for the chronic condition of the month, and disability living centres. We offer a similar variety of services to the Post Office. But let's not forget that because none of their services is indispensable, they are being slowly phased out.

Proposed uses for more than 10,000 community pharmacies include minor ailment clinics, anticoagulant monitoring services, obesity management clinics and suppliers of the contraceptive pill, to name but a few. No sign of any sort of master plan there either.

A quick straw poll of X Pharmacy staff created a wish list of fantasy pharmacy services.

Margaret and Jean voted for a Citizens Advice service, Anne suggested getting a nurse in to offer first aid and woundcare, and John the delivery driver thought a men's barber could just about squeeze into the consultation room. The list is endless because we're getting to a point where we will consider almost anything to make a living.

We should be playing to our strengths, not diluting our identity until we become some sort of pick and mix service supermarket. But here's the rub – I believe that pharmacy is having an identity crisis. As our recognised strength of medicines supply is in danger of becoming obsolete, no one is sure what to do next.

It's time to consider – do we want to work on a supermarket checkout or do we want to be recognised as healthcare professionals with a purpose?



Pharmacist in the House

Sandra Gidley

The times they might be a-changin'

There are a large number of all-party parliamentary groups (APPGs). There is one for practically every country on the planet and, when it comes to health, there appears to be a group for every condition known to man or beast. I have now reached the stage where I actively dissuade people from setting up yet another group. The proceedings of the pharmacy APPG are well reported in the pharmacy press but recent meetings of the APPG on primary care and public health have received scant attention.

The APPG has been conducting a short, sharp inquiry into access to primary care services. Somewhat predictably, representatives from the Society outlined what services could be provided by pharmacy and some of the doctors giving evidence were very clear that this was OK as long as it was all under the overall control of the doctor! Clearly, there is still a long way to go if we are to break down the traditional professional barriers.

Most interesting of all was the last session when Ben Bradshaw (the health minister who tops the pharmacy hall of fame as he has visited two pharmacies) and Mark Britnell (Department of Health lead for World Class

Commissioning) were before us. It was heartening to realise that Ben had picked up on the fact that enhanced services were not being commissioned in the way that had been originally envisaged. There was a hint that this would be

addressed in the forthcoming white paper, but I am not holding my breath.

The minister was then presented with data from IMS showing that 18 per cent of people visiting a GP were suffering from minor ailments. When asked whether pharmacists could take on this workload, the response was overwhelmingly positive. In Scotland there is a pharmacy minor ailments scheme and pharmacists are paid for their time and trouble. In England any

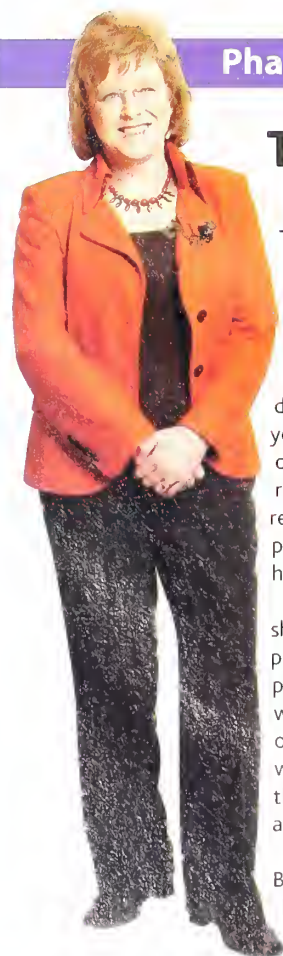
advice is given free and contractors are reeling from the category M clawback.

For the first time I suddenly felt that the times are a-changin'. Maybe, just maybe the profession is knocking on a door that is slowly starting to open.

So, gather round pharmacists, wherever you are and make sure that the pharmacy white paper is something that we can engage in, deliver and be proud of.

Sandra Gidley, Lib Dem MP and shadow health spokesperson

Just maybe
the profession is
knocking on a door
that is slowly starting
to open



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Letters

**Yogesh Patel MRPharmS,
JMW Vicary Ltd, Aylesbury**



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Letters

Widen campaign's influence

Congratulations on the Building Bridges campaign – pharmacists have long punched well below their weight.

An angle which is often overlooked is the local one. It is well worth pharmacists also trying to influence local politicians and councils. As well as being a possible gateway to the constituency MP, local councillors have powers and influence in their own right. While a backbench MP might be limited to influence, a local councillor could be involved in making decisions that affect pharmacy.



As well as your local ward councillor, bridges should also be built with the 'health scrutiny panel' and its chairman, as well as the portfolio holder for community care services. Health scrutiny is there to scrutinise local health services, including pharmacy. The portfolio holder for community care will have influence over service commissioning.

We have a great story to tell and can influence the debate and public opinion more than most pharmacists realise – if we engage.
Graham Jones MRPharmS,
leader, West Berks Council

Building on shaky ground

C+D's Building Bridges campaign targeted at MPs is to be applauded. But, unfortunately, the bridges being attempted to be built are being raised on very shaky foundations and are liable to collapse.

Our paymasters continually use the phrases "purchasing profits" and "excess profits" when chemist contractors supply drugs within the funding agreed in our contractual framework. Other professions are not tainted by such ideological emotive phrases when it comes to their remuneration.

But should we shoulder some of the blame?

Well, the RPSGB has admitted that for too long it has been persecuting and not promoting the profession; PSNC, in reality, a representative and not a negotiating committee; the NPA successfully represents pharmacy owners; and the CCA, the multiples. All this spread of representation is unique to pharmacy, clearly sending a

Our profession
blunders along
with no apparent
real leader at the
helm

message to politicians and government. But perhaps our profession blunders along, with no apparent real leader at the helm, which is then seen as an exploitable weakness.

Our only true supporters are the public, who persistently vote with their feet by consistently visiting our pharmacies to use our services. It will be only when there is a public outcry about loss of these vital easily accessible services that any government will listen or take notice.

J David Thomas, Patshull,
Shropshire



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CD Clinical

The first cut is the deepest

The main types of chronic wounds, their causes, and the principles of healing

Key points

- Chronic wounds tend to be suffered by people with underlying medical conditions, such as peripheral vascular disease and diabetes mellitus.
- Other systemic factors which contribute to wound healing include obesity, smoking and nutritional status.
- There are three main types of chronic wound: venous ulcers, diabetic, and decubitus (pressure) ulcers.
- Pain often accompanies chronic wounds, making analgesia an important aspect of wound management.
- There is no one dressing suitable for all chronic wounds. Instead, the wound should be continually assessed to ensure the correct dressing for the stage of healing is being used.

Sarah Cockbill FRPharmS

A soft tissue injury is defined as physical trauma where the skin is torn, cut or punctured (open wound). A closed wound is where blunt force trauma causes a contusion such as a bruise or sprain or where a ruptured blood vessel leads to blood collecting under the skin to form a haematoma. Open wounds may be acute or chronic. An acute wound is generally the result of elective surgery or an accident. In normal, healthy individuals wound healing is generally trouble-free when treated using well-established care standards and with modern wound management materials.

Wounds that do not heal within three months are often considered chronic. Such wounds seem unable to progress linearly from one or more of the wound healing phases. In acute wounds, there is a precise balance between production and degradation of molecules such as collagen by enzymatic activity (proteases) but in chronic wounds this balance is lost and degradation becomes predominant.

Underlying conditions, such as backflow from damaged venous valves, peripheral vascular disease, uncontrolled oedema and diabetes mellitus, are often to blame. This

Reflect

What underlying conditions can prevent wounds from healing? What other factors may change a healing wound into a chronic one? What would you recommend to prevent ulcers worsening on the skin of an immobile, incontinent elderly person?

Plan

This article describes the main types of chronic wounds and their causes.



This article can help in the following CPD competencies: **G1a, G1b, G1c, C1e, C2e, C3b, C3e, C3h**. See www.tinyurl.com/264zu



Foot ulcer on a 55-year-old woman. The black area is dead tissue. After one month after treatment, the foot was swollen on a regular basis, leading to the ulcer spreading.

Photo: Dr P. Marazzi/Science Photo Library

means that chronic wounds tend to be suffered by people over the age of 60.

Most chronic wounds can be classified into three categories: venous ulcers, diabetic, and decubitus (pressure) ulcers. Wounds caused after exposure to radiation or ischaemia may also become chronic. Leg, decubitus or diabetic foot ulcers may never heal or may take years to do so, causing severe emotional and physical stress as well as a significant financial burden for patients and the NHS.

Acute and chronic wounds are at opposite ends of a spectrum of wound healing types that heal at different rates. A number of environmental and patient factors may influence the transformation of a healing wound into a chronic wound, so healthcare professionals should adopt a holistic approach to wound management.

Venous ulcers Venous leg ulcers account for approximately 70 to 90 per cent of chronic wounds. They are thought to be due to venous hypertension caused by inefficient functioning of valves in leg veins, resulting in blood pooling. This leads to ischaemia and tissue damage, which ultimately lead to breakdown and ulceration.

Diabetic ulcers People with diabetes have a 15 per cent higher risk of amputation than the general population due to chronic ulcers. Diabetic neuropathy may result in patients failing to notice wounds to the legs and feet, and subsequent infection or repeated injury. In the longer term, diabetes causes immune compromise and damage to small blood vessels, thereby preventing adequate oxygenation of tissue. This can lead to the development of chronic diabetic foot ulcers. Pressure also plays a role in the formation of diabetic ulcers, particularly when patients have ill-fitting footwear.

Pressure ulcers Another leading type of chronic wound is decubitus or pressure ulcers. Decubitus is defined as any degenerative change caused by compression and shear forces on biological tissue. These ulcers usually occur in immobilised patients, when body parts such as the heels, shoulder blades and sacrum are subjected to increased pressure. Pressure ulcers are caused by the ischaemia that occurs when pressure on the tissue is greater than the pressure in capillaries, thereby restricting blood flow into the area. Muscle tissue, which needs more oxygen and nutrients than skin, shows the worst effects from prolonged pressure. It is important to be aware that reperfusion of the pressurised area can lead to increased tissue damage and care needs to be exercised when removing pressure from vulnerable areas.

Pain and chronic wounds

Patients with chronic wounds often report pain. Healthcare professionals should consider the management of pain related to chronic wounds as one of their main priorities as well as addressing the cause. Six out of 10 venous leg ulcer patients experience pain with their ulcer and similar trends are observed for other chronic wounds.

This persistent pain is caused by tissue or nerve damage and is influenced by dressing changes and chronic inflammation. It is important to remember that increased wound pain may be an indicator of complications that need treatment, therefore practitioners should constantly reassess the wound as well as the associated pain.

At present there are few local options for treating persistent pain, while managing the exudate levels present in



Repeated trauma, for example knocking the leg against a walking frame, can contribute to the formation of a chronic wound

many chronic wounds. If local treatment does not provide adequate pain reduction, prescribed analgesics may be necessary.

Systemic factors affecting wound healing

Poor circulation, neuropathy and difficulty moving are factors that contribute to chronic wounds but systemic illnesses, age and repeated

trauma also play a part. The skin of older people is more easily damaged, and older cells are slower to proliferate and respond to stress in terms of gene up-regulation of stress-related proteins.

Other problems that may contribute to the formation of chronic wounds include vasculitis, immune suppression, pyoderma gangrenosum and diseases that cause ischaemia that may be linked to a patient's old age. Smoking also reduces the capacity of the blood to carry oxygen to the tissue, impeding the healing process.

Ischaemia causes tissue to become inflamed and cells to release interleukins, chemokines, leukotrienes and complement factors that attract neutrophils to the wound area, prolonging the inflammatory stage. Immune suppression can be caused by illnesses or medication used over a long period, eg steroids. Stress also negatively affects wound healing by raising blood pressure and levels of circulating cortisol.

Obesity may cause problems because fatty tissue has a poor blood supply and may reduce circulation to the wound. Conversely, in an individual who is slight or emaciated, the lack of fatty tissue can reduce the padding of bony prominences and put them at risk of developing decubitus ulcers if they are immobilised.

Repeated trauma also plays a role in chronic wound formation by continually stimulating the inflammatory cascade. This trauma may occur by accident, eg when a leg is knocked against a supermarket trolley, or it may be intentional.

Adequate and appropriate nutrition is vital for efficient wound healing. Essential nutrients necessary for healing include proteins, carbohydrates, fats, vitamins and minerals. Defective collagen is produced in the absence of vitamin C and this may lead to haemorrhages and wounds breaking open. Vitamin C is also vital for the formation of intracellular proteoglycans. There is evidence showing increased requirements for vitamin C during injury, stress and sepsis. It is thought that vitamin C supplementation may be useful in the prevention of skin ulcers because it has been shown that a low leucocyte ascorbic acid level is a predisposing factor for the development of decubitus ulcers and the non-healing of other chronic wounds such as leg ulcers. For these patients 1g per day has been shown to be beneficial, probably because the greatest percentage of these patients are elderly and possibly malnourished.

B-complex vitamins are co-factors or co-enzymes in a number of metabolic functions involved in wound healing, particularly in the energy release from carbohydrates. Vitamin K is involved in the formation of thrombin, and deficiency in the presence of wounds could lead to a haematoma. Vitamin A is involved in the cross-linking of collagen and the proliferation of epithelial cells.

Zinc is required for protein synthesis

and is a co-factor in enzymatic reactions. There is an increased demand for zinc during cell proliferation and protein secretion. Zinc has an inhibitory effect on bacterial growth and is involved in the immune response. Iron is a co-factor in collagen synthesis, and deficiency in iron delays wound healing. Copper is also involved in collagen synthesis.

Local factors affecting wound healing

The cells involved in wound healing need a moist environment to function effectively. Modern wound management materials are designed to ensure that the microenvironment surrounding the wound at the skin surface is moist but not macerated.

If infection is suspected, swabs should be taken to identify the causative organism and appropriate systemic antibiotics given if necessary. Materials containing antibacterial agents such as nanocrystalline silver and chlorhexidine are available to treat infections superficially but should not be used long term. As more oxygen in the wound environment allows white blood cells to produce reactive oxygen species to kill bacteria, patients with inadequate tissue oxygenation, eg those who suffered hypothermia during surgery, are at higher risk of infection.

A significant amount of exudate and necrotic tissue in a wound increases the likelihood of infection by serving as a medium for bacterial growth. Debridement and drainage of wound fluid are an especially important part of the treatment for diabetic ulcers. Wound irrigation mechanically removes bacteria and devitalised tissue and is accomplished by using pulsed lavage.

Necrotic tissue appears black and must be removed from the wound surface before healing can start. Yellow slough should also be removed as this can delay healing and encourage infection. Maggots remove necrotic or devitalised tissue. They produce proteolytic enzymes (proteases) that dissolve only necrotic, infected tissue and disinfect the wound by killing bacteria. This stimulates wound healing, and reduces both wound odour and pain. The combination and interactions of these actions make maggots an extremely potent tool for chronic woundcare.

Vacuum-assisted closure reduces swelling in tissues and brings more blood and nutrients to the area. The treatment decompresses tissues and alters the shape of cells, which causes them to express different mRNAs, to proliferate and produce extra cellular matrix (ECM) molecules.

Incontinence may lead to infection if it occurs near an unprotected wound.

Healthcare professionals should continuously monitor the skin of immobile patients for the appearance of red patches, in which case vapour-permeable films and polyurethane foams should be applied to prevent ulcers forming or worsening.

Treatment

It is important to emphasise that no existing product will be appropriate for managing a wound through all healing stages, from its onset until healing has occurred. The wound and its healing must be continually monitored to ensure the most suitable dressing is being used. For example, a very absorbent dressing may be needed to remove excess exudate at the inflammatory stage of the wound healing process, but as the exudate reduces, dressings with decreasing absorbency can be used.

Though treatment of the different chronic wound types varies slightly, appropriate treatment seeks to address the problems at the root of chronic wounds, including ischaemia, bacterial load and imbalance of proteases.

Dr Sarah Cockbill FRPharmS is a teaching fellow at the Welsh School of Pharmacy, Cardiff.

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Continuing Professional Development



Act

- Read the British National Formulary chapter on wound dressings.
- Using the BNF, Drug Tariff and the C+D Guide to OTC Medicines & Diagnostics, make a table listing the different types of wound dressings, the stage of wound healing for which they are used, how they should be used (ie whether a secondary dressing is needed) and their brand names. Make a note of the brands you stock. Do you have a sufficient range to meet local needs? If there is a dressings formulary in your area, try to obtain a copy.
- Find out what each dressing type looks like, so that if a patient describes something used in hospital, for example, you would be able to obtain an equivalent product.
- If local tissue viability nurses obtain their dressings from you, discuss with them possible ways of making their prescribing more cost effective. Are they using any products for which there are equally good but cheaper alternatives, bearing in mind that a more sophisticated (and therefore expensive) product may decrease healing time?
- Read the National Prescribing Centre's MeReC Extra Issue No 31 summary on modern wound dressings http://www.npc.co.uk/MeReC_Extra/extra2007.htm
- Read Cancer Research UK's website <http://www.cancerhelp.org.uk> on ulcerating tumours and what patients can do about them.
- What diet (including supplements) would you recommend for a wheelchair-bound elderly lady with a pressure ulcer?

Evaluate

- Would you now be able to talk knowledgeably to, and understand the requirements of, local tissue viability nurses?

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A Practical Approach

Registration and retention fees

Salma Hussain, formerly pre-registration pharmacy trainee at Update Pharmacy, bumps into a former fellow pharmacy student while shopping and they start chatting.

"What have you been up to since we qualified, Rosalind?" Salma says. "I got married soon after I finished my pre-reg and I've been working for a large multiple. I did a few months locuming after qualifying, and now I'm managing an independent. But I'm not sure pharmacy's the career for me.

"I'm thinking about doing a law degree and becoming a solicitor, but I'd want to be able to carry on doing locums to help finance my studies. I might be able to get a reduction on my RPSGB retention fee as I'll only be working part-time. But enough about me. What about your plans?" Salma asks.

"Well, I've just found out that I'm pregnant," Rosalind replies.

"Nick's got a good job and I was hoping to stay at home until my kids go to school and then start working part-time.

"But I'm not sure what the difference is between becoming non-practising and retiring from the register. And if I do either, will I be able to get back on without problems? I suppose I could just let my registration lapse and worry about it if and when I want to get back on."

Questions

1. Would Salma be entitled to a reduced retention fee if she was working part-time?
2. What is the difference between remaining on the register as non-practising and retiring from it?
3. What would happen if Rosalind let her registration lapse?



Bethany Straker

1. There is no reduction in retention fee for pharmacists working part-time, regardless of how little they work in pharmacy. There is also no reduction in CPD requirements for part-time pharmacists. The RPSGB states: "A pharmacist is deemed to be practising if he or she undertakes any work in, or gives advice in relation to, the science of medicines or the practice of pharmacy or health care." The Society's interpretation of such advice is anything beyond that which an ordinary member of the public would be qualified to give. Non-practising pharmacists must sign a declaration stating that they will not practise, but continue to be subject to the Code of Ethics. They can use the restricted title pharmacist but must explain, when using it, that they are not practising. The non-practising retention fee is £67.

2. Currently, there are no special requirements for returning to the practising register beyond paying the full practising fee of £395. Pharmacists who retire from the register may offer any pharmaceutical advice that they wish. If they wish to re-register within a year of retiring they must pay a restoration fee of £191 plus the practising fee.

3. A pharmacist's name is deleted from the register if the retention fee is not paid within three months of demand. The restoration fee in this situation is £753. There are currently no special requirements for re-registering after voluntary retirement or deletion for non-payment of fees.

Answers



This article can help in the following CPD competencies: **G1g, G1h, G1m**. See www.tinyurl.com/194zu

Clinical News

HBA_{1c} reduces falls

Elderly patients who achieve tight HBA_{1c} control using insulin are less likely to fall, a study of 446 patients published by the journal Diabetes Care has revealed. <http://tinyurl.com/2zhqrd>

authors of a study have argued in the BMJ. www.bmj.com

Early AMD risks

Age-related macular degeneration is associated with double the risk of dying from a stroke or heart attack, Australian researchers have said in the British Journal of Ophthalmology. bjo.bmj.com See www.chemistanddruggist.co.uk/clinical for clinical news.

Immunisations down

Children are receiving too few immunisations to prevent outbreaks of infectious disease,

A sparkling new choice for your patients

Adcal-D₃® Dissolve – give your patients a choice of formulations



Further information is available on request from: ProStrakan Limited, Unit 1, Park Business Park, Gelashalls TD1 1QH, Leamington, P. Adcal-D₃ is a registered trademark of ProStrakan Ltd. Date of preparation: 20th November 2007, J003/019

Adverse events should be reported to ProStrakan Ltd on 01896 641001. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

Please consult Summary of Product Characteristics before prescribing Adcal-D₃ Dissolve particularly in relation to side effects, precautions and contraindications. Adcal-D₃ Dissolve is used as an adjunct to specific therapy for osteoporosis and in situations requiring therapeutic supplementation of malnutrition.

Adcal-D₃ DISSOLVE
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www.prostrakan.com

HRT link to cancer persists after stopping

Women on combined HRT are at increased cancer risk for years after stopping the medication.

A US study, published in this week's JAMA, followed up nearly 16,000 women involved in the Women's Health Initiative trial, which was stopped early when it became clear that the risks of HRT outweighed the benefits.

This post-intervention research found that cardiovascular risk and hip fracture benefits had dissipated within three years

of the trial ending, but cancer risk had increased.

The reason for this may be that taking combined HRT appears to reduce the risk of colon cancer, but increase that of breast malignancy.

After stopping HRT, researchers discovered that the protection against colon carcinoma diminished, whereas the heightened breast cancer risk appeared to persist.

JAMA 2008; 299(9): 1,036-45.

Anticholinergics good for incontinence

Anticholinergic drugs, pelvic floor muscle exercises and bladder retraining can resolve symptoms of urinary incontinence, according to a review of 96 trials published by the Annals of Internal Medicine.

However, studies of the effects of electrostimulation, devices, injectable

bulking agents and local oestrogen therapy proved inconsistent.

Oxybutinin and tolterodine were both effective in resolving symptoms, and duloxetine improved but did not resolve them.

<http://tinyurl.com/2yro6b>

Clinical Alerts

MHRA Alerts

SmartCheck INR system (Unipath)

Recalled by manufacturer due to risk of inaccurate results, leading to incorrect anticoagulant dosing. All meters should be returned to Unipath and all consumables destroyed. All patients should be reviewed as soon as possible. See <http://tinyurl.com/2zlh2b> for more information, or contact Unipath, tel: 01234 835811.

New Products

Fucibet Lipid cream 30g (fusidic acid 2 per cent, betamethasone valerate 0.1 per cent)

Licensed for the treatment of eczematous dermatoses with secondary bacterial infection in patients aged six years and over. Leo Pharma, tel: 01844 347333.

Rapydan plasters (lidocaine 70mg, tetracaine 70mg) Indicated for skin anaesthesia before needle puncture and minor surgery. Eusa Pharma, tel: 01438 740720.

See www.chemistanddruggist.co.uk/clinical for more clinical alerts.

What's terrifying for them is everyday for me.

When I'm making my decision, I think about my family. For a few minutes, the family inside is more important than my own.



Adverse events should be reported to Pfizer Medical Information on 01304 615161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk. Consult Summary of Product Characteristics before prescribing, particularly in relation to side effects, precautions and contraindications.

Further information on request: Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey, KT20 7NS. Legal category: POM. Lipitor is licensed to reduce cholesterol in hyperlipidaemic patients. Date of preparation: December 2007. Item code: LIP2933j



My life.

LIPITOR
atorvastatin

Your decision.

Ashes to

Has the smoking ban boosted sales of NRT products or will the government need to resort to more persuasive tactics to encourage smokers to quit? **Lesley Ribbens** finds out



How much more encouragement do the nation's smokers need to make them quit? Smoking bans, hard-hitting TV commercials, blunt messages on tobacco products, tax hikes on the addictive weed, even free NRT.

Yet a stubborn quarter of the population continues to jeopardise their health and the health of those around them.

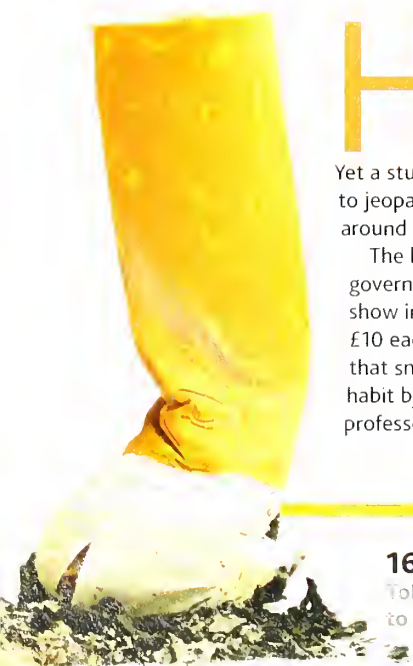
The latest stick to be waved at smokers is the idea of a government smoking permit that smokers would need to show in order to purchase cigarettes. Costing perhaps £10 each year, with profits going to the NHS, the hope is that smokers would be deterred from 'opting in' to their habit by the onerous form filling. Julian Le Grand, professor at the London School of Economics, came up

with the concept and it is under consideration by Lord Darzi, health minister responsible for NHS reform.

Later this year, the Department of Health will consult on the next steps in tobacco control and the further regulation of tobacco products, including issues around the display of tobacco at the point of sale, access to tobacco from vending machines, and packaging.

Last year the ban on smoking in enclosed public spaces in the UK became complete as Wales, Northern Ireland and finally England followed where Scotland led in 2006. The legislation is proving popular with the majority, with just 15 per cent of respondents to a survey by the Office for National Statistics saying they disagree with the law.

The smoking ban triggered a big increase in quit attempts and an "unprecedented demand for stop smoking services",



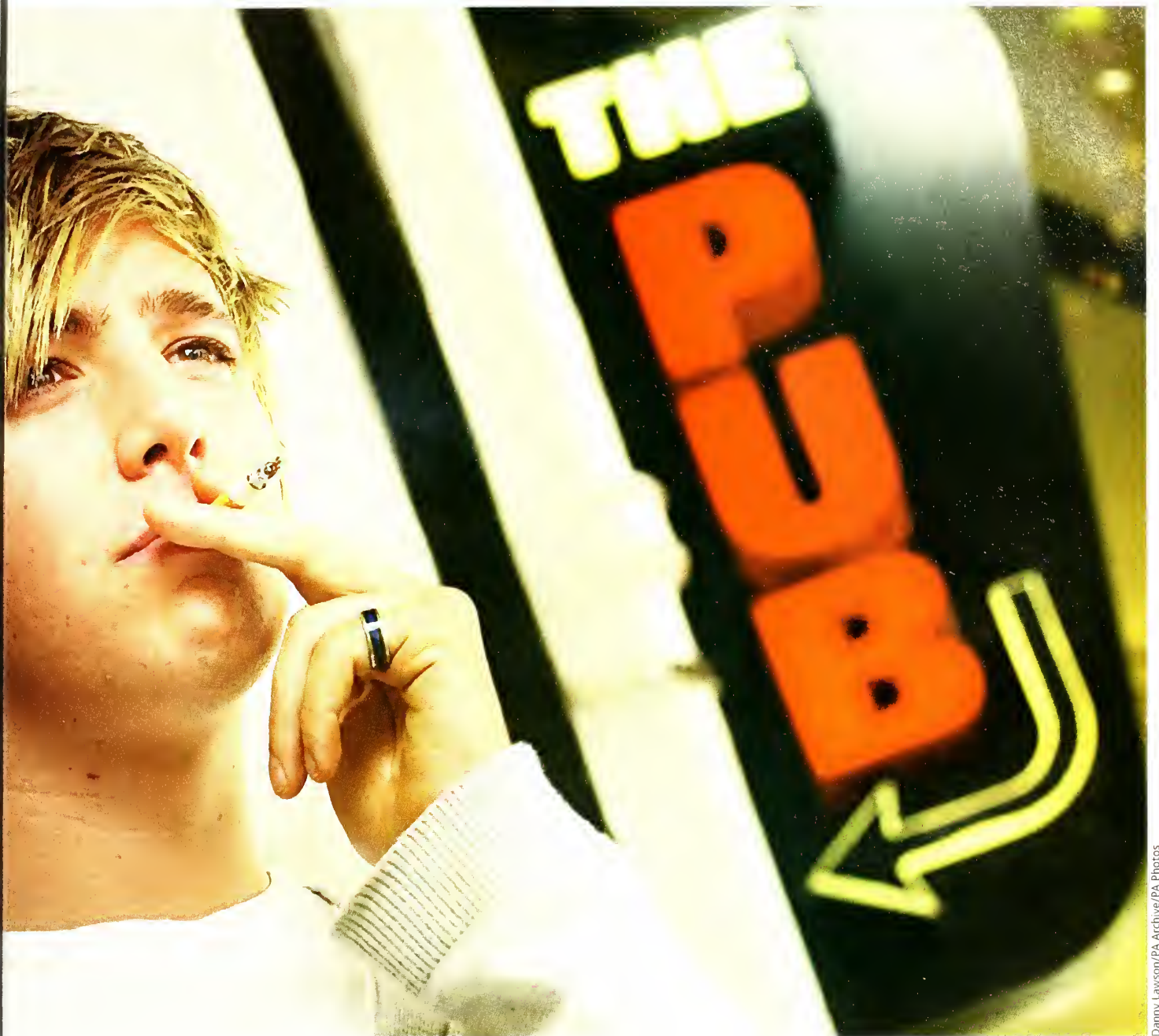
16th century
Tobacco introduced to England

1856
First cigarette factory opened in Walsworth, England

1858
Smoking health fears first raised in The Lancet

1992
Nicotine patches introduced

2003
Tobacco advertising banned in the UK



Danny Lawson/PA Archive/PA Photos

says the DH. Between April and September last year around 165,000 smokers quit – up 28 per cent on the same period the previous year.

Calls to the stop smoking hotline have been boosted by the DH's 'Getting off cigarettes' campaign that began on December 26 and runs for three months. Figures to January 13 show around 9,000 people called the helpline and 73,000 visited the related website. Interactive TV and text messages were used to make 13,000 requests for information packs.

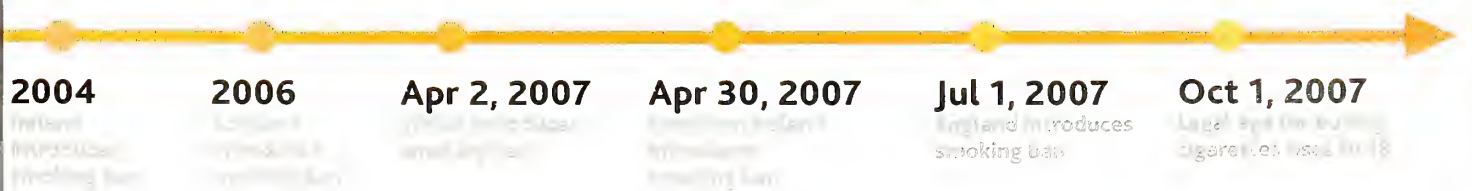
The increase in quit attempts brought more sales for the NRT sector as smokers sought support in giving up. Market data from AC Nielsen shows the total NRT market for 2007 was up 8 per cent on the previous year in terms of units sold. At the same time cigarette sales fell 4 per cent.

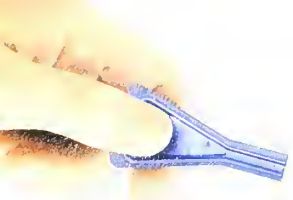
Disappointingly, the pharmacy market saw a decrease in its

sales of 4 per cent year-on-year while the grocers grew their share by almost 32 per cent. But pharmacy still holds a commanding 58 per cent of sales by volume and 61 per cent by value. The most popular formats in pharmacy are patches (2.276 million units), gum (2.195m units) and lozenges (887,496 units).

While the smoking ban has persuaded some smokers to quit, it's debatable how effective it is to criticise smokers about their habit. Richard Madley-Dowd, NiQuitin sales and marketing manager at GSK, believes pharmacies should focus on positive messages. "Shoppers are looking for support in their quitting attempts, rather than reminders of the dangers of smoking. Creative solutions should ideally carry a positive theme, ie portraying the implications of smoking but focusing on the benefits of quitting," he says.

Banishing smokers from enclosed public spaces has been instrumental in increasing the numbers of those seeking to quit the habit





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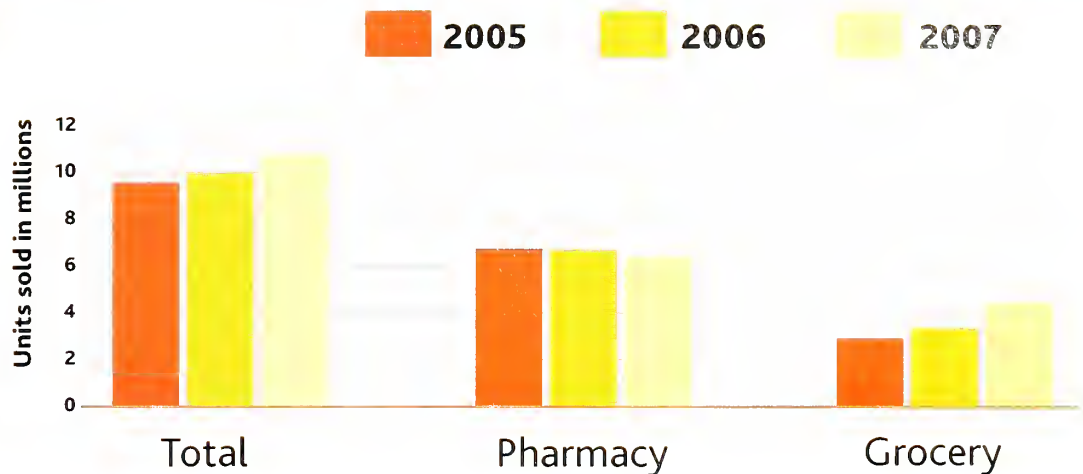
FRONTLINE® Spot On contains (ipronil) [NFA-VPS]. ©Registered Trademark.
For further information contact Merial Animal Health Ltd, CM19 5TG, UK.
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FRONTLINE®
Spot On

The gesture of love you can trust

NRT sales



Source: AC Nielsen

Merchandising advice

NRT products are widely considered 'wellbeing' products: a means to a healthier lifestyle rather than a treatment. According to GSK, customers spend a lot of time browsing smoking cessation aids yet 30 per cent do not make a purchase. They may find the options confusing, so clear signposting and education is essential to help customers understand different approaches, formats and strengths. Research has shown products should be segmented by format, then brand, then strength and flavour. If space permits, P formats should be highlighted, adds GSK.

Language should be consumer friendly so use 'stop smoking' rather than 'NRT' or 'smoking cessation'. Pharmacy's trump card over the supermarkets is advice, so ensure all staff know how to spot smokers and offer advice. Learning the benefits of quitting can be great motivation for potential quitters.

Mr Madley-Dowd comments: "The world of pharmacy is changing, with a greater focus on the pharmacist taking an active role in improving the health of the local population. Despite pharmacies having created consultation rooms, it appears that many have not yet secured funding from the PCT to run community stop smoking clinics. GSK has provided guidance on how to engage the PCT to achieve this, utilising a pharmacy business planning approach. In addition, GSK supports pharmacy through its educational programmes and merchandising support – see the MyPharmAssist.co.uk website for details."

If the momentum of the smoking ban has now worn off, this week's National No Smoking Day on Wednesday should boost interest and chivvy a few more potential quitters through the pharmacy door. So be prepared!

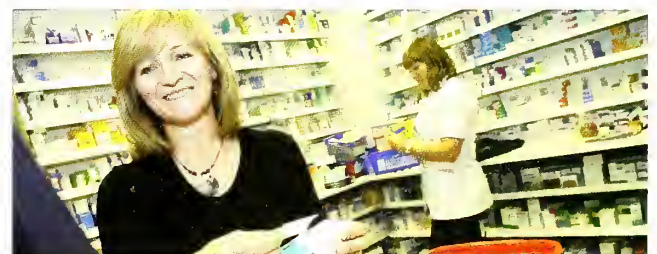
Top merchandising tips:

- Products should be segmented by format, then brand, strength and flavour
- Highlight P formats if space permits
- Use consumer friendly language such as 'stop smoking'
- Play your trump card and ensure staff know how to spot smokers and offer advice

Advertisement feature

CAMBRIDGE PHARMACIST HAS TO MAKE EVERY SECOND COUNT, SHE SAYS.

Carolyn Verma, Cambridge Pharmacist, says: "I think that in a busy pharmacy, you have to be very efficient. I think that in a busy pharmacy, you have to be very efficient. I think that in a busy pharmacy, you have to be very efficient."



Not so. Her shop, Kays Chemist, has two surgeries within a stone's throw and, less positively, several nearby supermarkets. The result? Like many independents, Carolyn has very high footfall, lots of competitive pressures and a lack of time to do everything.

She has to focus hard on what will yield most results.

"The business is losing counter sales due to the proximity of so many supermarkets" Carolyn says, "...and new services are hard to develop when there's so much prescription work to handle."

"We must ensure that we maximise the use of everyone's time here

in delivering pharmacy processes – it's the only way to increase profitability," she reveals. Such discipline includes use of Numark schemes, for not one, but two reasons.

"They are principally very competitive, with great prices on generics, PIs and branded products. I'm confident across the whole range I get an excellent deal. But it also saves time on short liner phone calls, writing orders on pads and endlessly searching lists for best offers. Some people might have time for all that – I don't!"

Kays Chemist profits are up.

NUMARK+

CASE STUDY:
Rowlands' POSitive approach

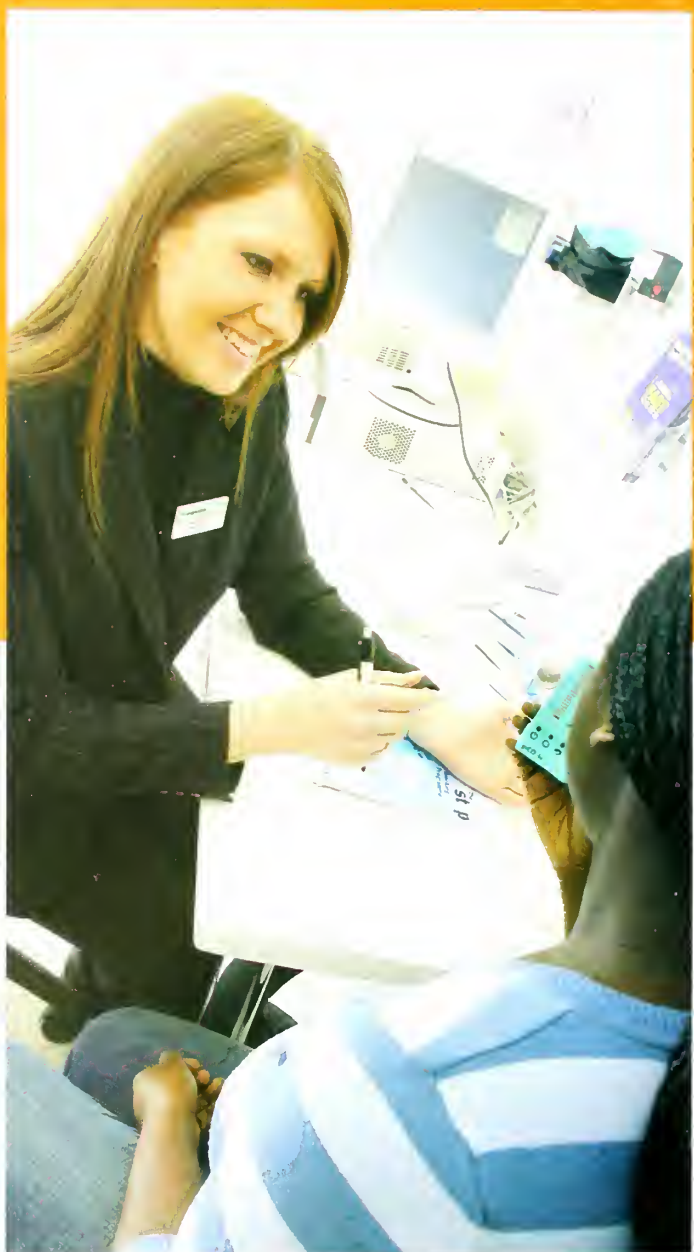
Rowlands pharmacies have been using an advice-driven sales format for the last five years. As Georgina Webb, category manager at the chain, explains, it's important to help customers make informed choices. "We aim to provide advice at the point of purchase. Our pharmacies have eye-catching merchandising which helps to focus their mind on what they have to do. This makes it much easier and clearer for the customer to choose the correct product for them. Our point of sale explains what processes the quitter's body goes through at each stage of the quit cycle and we also offer a useful three-stop guide which again helps customers choose the right NRT support."

CASE STUDY:**Co-op's collective approach**

Smoking cessation is currently available in around 250 Co-op pharmacy branches, as a service commissioned by primary care organisations. The business liaises with PCOs on behalf of branches and supports them with window posters and leaflets, mobile display stands, branded giveaways and free "taste tester" samples for customers. A new 'Giving up Smoking' leaflet is currently being distributed to branches.

Kate Molyneux (pictured, right), pharmacist at the Co-op's Birchwood branch in Warrington, began her smoking cessation service in January 2004 and has helped more than 400 patients. Says Kate: "The service runs in conjunction with the Warrington stop smoking service. They had their own advisers and wanted to roll the service out into pharmacies. My pharmacy was one of the trial locations and I then helped with the training of other pharmacists."

The number of quitters seen in a week varies quite a lot and Kate says she saw an uplift in interest ahead of the introduction of the smoking ban last July. The pharmacy is located in a small shopping centre with a GP surgery and offices nearby, so attracts a wide range of customers of all ages.

**Product news round-up****NiQuitin makes stop smoking signals**

To boost interest in this week's No Smoking Day, NiQuitin has been distributing a resource pack to healthcare professionals. Including stickers, bunting, window display materials and consumer leaflets, the pack is being given to pharmacies, GP surgeries and stop smoking advisers.

The brand offers quitters an individually tailored support plan via its website, www.click2quit.com. Said to complement NHS services, the plan claims to be the only online programme proven to improve quit rates (source: Addiction 2005; 100: 682-688).

The NiQuitin range includes lozenge and gum formats to allow users to control their cravings. The lozenges are also said to help curb an increased appetite, which is often associated with quitting.

Nicorette news

The Nicorette Inhalator has switched from P to GSL as an aid to smoking cessation and an aid to reduction prior to quitting. Meanwhile, the patient information leaflet for Nicorette Microtab is the latest 'PIL of the month' on the MHRA's website. It is said to be an example of best practice, scoring highly for its design and layout.

Nicotinell's ad burst

Support for Nicotinell in the run-up to Wednesday's No Smoking Day includes Life Channel TV advertising and sponsorship in more than 1,000 GP surgeries and 123 pharmacies. Online activity centres on the brand's www.keepthefire.co.uk site. A mobile quit pack is available to download direct to phones.

Facts & Figures**£56m**

Total revenue from the sale of smoking cessation products in the UK in 2007

Source: Department of Health

22

Percentage of adults in England who smoke in 2007

Source: DH

50

Percentage of quit attempts that are spontaneous

Source: Tobacco Control

x6

Factor by which NRT plus behavioural support increases a smoker's chance of quitting compared with willpower alone

Source: Thorax

Just For Men in TV comeback



Because
the best
is yet
to come

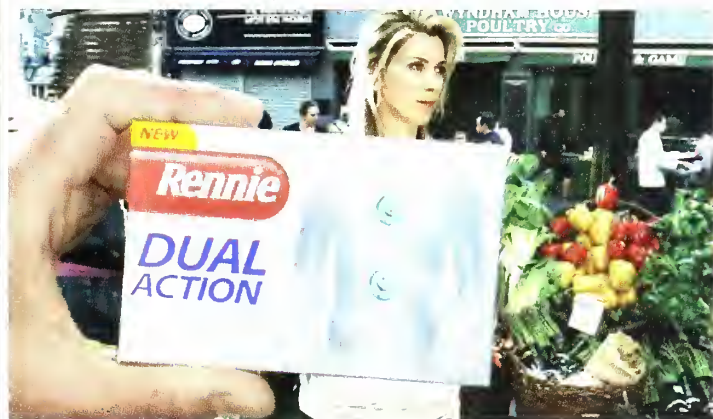
Just For Men hair colorant begins a TV ad campaign this week. Breaking on March 10, the advert will be seen in all regions for four weeks. The campaign forms part of a £4 million promotional spend for the brand, reports Combe International.

The ad features men explaining their reasons for wanting to get rid of their grey hair. It ends with the strapline: "Because the best is yet to come."

Just For Men is a five minute shampoo-in hair colour said to target only grey hair. Each application lasts up to six weeks. Eight shades are available, complemented by a range of brush-in colour gels for facial hair.

Product info:
Combe International
Tel: 0208 680 2711
<http://uk.justformen.com>

Rennie goes for burn



Rennie Dual Action is being advertised on television as part of a £6 million media campaign.

Running on terrestrial and satellite channels until late April, the ad features a woman helped by the product when heartburn threatens to spoil her day. It highlights the brand's claim to give relief in two minutes and its antacid and alginate formulation.

Manufacturer Bayer hopes the activity will help maintain the brand's recent strong growth. Within the pharmacy sector, Rennie holds 19 per cent of the indigestion and heartburn market

by value and is growing at 8 per cent per annum (source: IRI 52 weeks to Dec 29, 2007).

Product info:
Ceuta Healthcare
Tel: 01202 780558

C+DAWARDS
Only one week left
to submit your entry
– closing date
March 14

Warm reception for Magicool at Dendron

Dendron is the new distributor for the Magicool and Magicool Plus products from FranceMed Pharma.

Strong sales are predicted for the brand this year, boosted by a £1 million TV advertising campaign scheduled to run during the summer.

Peter Dutton, Dendron's

commercial manager, says as the UK's only self-chilled, cooling spray, Magicool is "a great fit with the company's long-term health and beauty strategy".

Product info:
Dendron
Tel: 01923 229251



ELSEWHERE...

...we tell you how Carolyn Verma's pharmacy tackled increased competition by being single-minded about use of time. She uses Numark schemes as part of this process.

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... you can start finding out how to do the same.

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NUMARK+

Clean up with Faith in Nature

Faith in Nature has launched 3-in-1 Facial Wipes, aiming to fill the gap in the natural personal care market.

The wipes cleanse, moisturise and remove make-up and are positioned as the first natural product of this type to be manufactured in the UK.

The hypoallergenic and fully biodegradable wipes are free from parabens, sodium lauryl sulphate and its derivatives, and alcohol. Made from viscose, the wipes are impregnated with essential oils, aloe vera, allantoin and vitamin C. Presented in a purse size



pack, the facial wipes are the first in the Faith in Nature range to be given the new design and are said to reinforce the company's traditional ethical values with attractive modern styling.

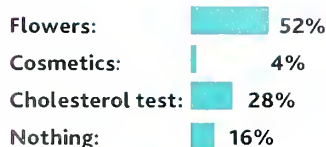
The wipes are on offer at an introductory £2.79, which is a reduction of 20 per cent off the normal price.

Price: £3.49/25
Faith in Nature
Tel: 0161 764 2555

Retail TALK

What will you be buying your mum for Mother's Day?

WEB VERDICT:



Off the shelf view: It looks as if the florists' tills were ringing out the loudest last weekend. But it's good to see a sizeable portion of voters staying true to their healthcare professional roots and prioritising mums' health and wellbeing. Shame on those of you buying nothing!

This week: Are you actively promoting your smoking cessation expertise in the run up to No Smoking Day on March 12? Vote online at www.chemistanddruggist.co.uk

Stand delivers

A leaflet display stand designed to help pharmacists meet the essential services criteria of the pharmacy contract has been launched by Waiting Room Information Services.

The floor standing, rotating Help2Health stand is supplied with 2,000 leaflets from the pharmaceutical industry, government and charities. The stand is restocked by the company every three months and has space for local information to be displayed.

In a pilot scheme covering 45 pharmacies, 95 per cent of pharmacists said they wanted to keep the Help2Health stand and 71 per cent said it had improved 'pick-up' rates in the pharmacy. More than one in five (23 per cent) said the service had opened up the opportunity for a medicines use review.

A refundable deposit of £99+VAT is the only cost involved.

Product info:
Waiting Room Information Services
Tel: 01489 860000
www.ids-international.info

Malibu's babes offer a ray of sunshine

Malibu Babes is the latest addition to the Malibu suncare range.

Funky graphics and a colourful design aim to catch the eye of young women, who are the target audience for the new products.

There are 11 variants available: lotions with aloe vera from SPF6 to SPF30, gels containing carrot extract in SPF10 and SPF15, two shades of SPF20 lip gloss, a tan prolonging aftersun lotion and aftersun gel with aloe vera.



Price: from £2.99 to £4.99
Malibu Health Products
Tel: 020 8758 0055
sales@malibusun.com

Optrex itching to go

Optrex Itchy Eye drops is the latest addition to Reckitt Benckiser's eyecare range.

The product is suitable for relieving irritation caused by pollen and should be sited alongside other seasonal products such as antihistamines, suggests RB. It contains witch hazel to soothe and refresh eyes and, once opened, lasts 28 days.

The range will be advertised on

television from April to July to coincide with the hay fever season.

• A 10ml bottle of Brightening drops has been launched to replace the existing 8ml pack.

Price: £3.99/10ml
Pip codes: Itchy 334-2532; Brightening 334-2524
Reckitt Benckiser
Tel: 01482 326151



Products advertised on TV next week

Anadin Extra & Ultra: All areas
Bio-Oil: All areas except GMTV
Buscopan: GMTV
Covonia: GMTV, Sat, five,
Cura-Heat: All areas, except GMTV
DulcoEase: GMTV, Sat, five, LWT, CAR
Just For Men: All areas
Lyclear SprayAway & Repellent: GMTV, Sat
NiQuitin: All areas
Seven Seas JointCare & CLO: All areas
Vagisil Creme: All areas
PharmaSite for next week: Meltus – windows, Meltus – in-store, Meltus – dispensary
Pharmacy channel: NiQuitin, Fusion Condoms, Clearly Herbal

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire



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Booking and copy date
12 noon Monday prior
to Saturday publication subject
to availability

Contact:

Simon Pittman
Chemist + Druggist (Classified),
CMP Information Ltd
Ludgate House
245 Blackfriars Road
London SE1 9UY

T: 0207 921 8119

F: 0207 921 8130

www.chemistanddruggist.co.uk
c&dsales@cmpi.biz

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Ludgate House, 245 Blackfriars Road,
London, SE1 9UY
enclosing an introductory letter and
a copy of your CV.

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WEST SUSSEX
Superintendent Pharmacist

We are a growing independent pharmacy with an exciting business plan looking for a superintendent pharmacist to manage our pharmacy and work with us in developing our expansion. You must be business minded, totally patient orientated, have excellent communication skills and be experienced in MDS management. Attractive package offered to the right candidate.

For an informal discussion, please contact
Roger Button on 07887 777974

Dispensers / ACTs

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For further details or enquires please phone
Richard Lister on 0208 950 3370 9am – 7pm

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For an expanding company based in St Albans, we are looking to recruit in the following areas: St Albans, Fordingbridge, Ashford (Kent) and Birmingham.

Organised and self-motivated individuals to assist in the provision of pharmacy services to Care Homes and home based patients referred by hospitals.

No previous experience in this sector is necessary as full training will be provided.

This is a unique opportunity to work in the growing areas of Home Care Dispensing Services.

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Pharmacy Assistant

Pharmacy Technician - London

London SE18 based Pharmacy seeks to appoint a Pharmacy Technician. Duties and responsibilities to include advice on pharmaceutical products, supplies, dispense prescriptions, dossett packing for care homes, control stock, ensure effective service to customers, supervision of support staff, preparation of products. Must be able to work independently, and be willing to work long hours and weekends also undertake home deliveries.

Must have relevant skills acquired through three years working experience in this field at NVQ level three or above.
Salary £18-20k

Applications to:- St James medichem Ltd
pharmacyadmin@googlemail.com

Closing date for applications: 1st April 2008

Pharmacy Assistant

SE24 – PART-TIME SALES ASSISTANT

required at our small but busy pharmacy in Herne Hill, London SE24. 15 – 20 hours per week with flexibility to cover sickness and holiday periods. You must be a cheerful person with excellent communication skills, keen to join our hardworking and committed team.

Please phone Roger on 07944 831 784 or email fourway@npanet.co.uk with your CV.

www.fourwaypharmacy.co.uk

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BUYING ASSISTANT - FULL TIME
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To help us do this we have a vacancy for a buying assistant to work with the buyer to assist in the negotiation and delivery of commercially viable programmes with pharmaceutical suppliers to the benefit of our members. An element of the role will also involve collating market intelligence which will impact on decision making.

The ideal candidate will be educated to O-level or equivalent standard and computer literate. They will be organised, possess a high degree of self motivation and have the ability to communicate effectively with our stakeholders. Knowledge of pharmacy would be advantageous though this is not an essential requirement. Previous buying experience would be preferred.

If you feel you have the necessary skills and are interested in this position, please submit your CV and covering letter to:

Sundeep Nagra, Pharmacy Buyer, Numark Ltd, 5/6 Fairway Court, Amber Close, Tamworth, Staffordshire, B77 4RP.

Or email Sundeep.nagra@numark-central.co.uk

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ADDING VALUE

From: **Hawkeye on the web**

Date: Sat 8.3.08

Subject: ...Boots are made for...



Much is spoken of Boots' presence at the heart of the UK high street, but this week research showed the brand has carved out an equally powerful niche in cyberspace.

Using data from web tracking firm Hitwise, the Private Healthcare UK WebWatch report discovered that Boots-related searches accounted for a quarter of all health and medical googlings in the four weeks to January 26 (www.tinyurl.com/2lm59c).

Yep, amazingly, the UK public is more likely to hunt for four different variations on a Boots theme before they get round to looking for Viagra.

On a wider scale, the report gives an interesting insight into the profile of healthcare

surfers. It seems they are more likely to be female (56.2 per cent compared with 51 per cent for the web as a whole); under 45 years old (although a sizeable 37 per cent are 45 plus); and trying to find information on obesity, weight loss and dieting (when they're not at Boots).

And, almost certainly, they will look for information via Google, which will be music to the

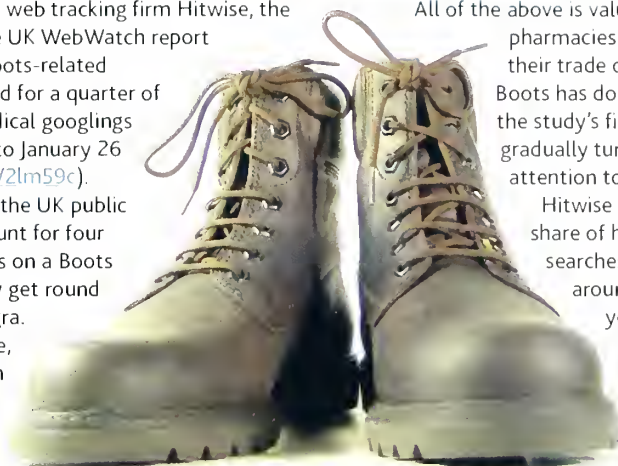
search behemoth's ears, since this week it outlined further plans on the Google Health project discussed in last week's column (www.tinyurl.com/27tkdw).

All of the above is valuable information for pharmacies looking to expand their trade on the internet as Boots has done. Less positive is the study's finding that people are gradually turning their online attention to other things.

Hitwise calculates that the share of health and medical searches has dropped by around a third in the last year, as people prefer to spend their time on more important matters (like Facebook).

In this context, Boots' ability to

secure loyalty from fickle online consumers is even more impressive. Or maybe all that publicity around supplying Viagra under PGD was a masterstroke in online marketing?



People **prefer** to spend their time on more **important matters** (like Facebook)

What do you think?

Email thawkins@cmpmedica.com

... your views on the C+D website ...

Who would want to be a pharmacy manager?

 Posted by Anonymous on 25/02/08 12.38

"As a locum, you are only expected to dispense prescriptions and advice, which means you have the luxury of enough time to provide proper patient care. Isn't that why we got into this game in the first place?"

 Posted by Ken Sims on 24/02/08 11.56

"After 30 years I sold my pharmacy to a friend. He sold to another friend; ownership passed to a small company, then to a larger, and finally to a national... The shop is impersonal, with ever-changing faces, looking harassed and less than ecstatic. I read that 80 per cent of pharmacists favour a new Society, like a trade union, to represent pharmacists... and employers? Together? We want our heads examined."

Exemption fuels Asda growth bid

 Posted by Mukesh Lad on 29/02/08 10.46

"The truth is, giant corporations start taking over everything and customers start losing local services and small businesses... then they shout and scream at the government, they in turn realise too late, and introduce laws such as 'anti-predatory' laws. But then it's too late!!"

 Posted by Anonymous on 03/03/08 11.31

"Many 100-hour pharmacies are so quiet at unsociable hours that managers find it difficult to justify providing trained counter staff... so it ends up being a locum on duty with someone drafted in from the shop floor, with no pharmacy training at all. And who wants to work like that?"

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